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DEVOTED TO DISEASES OF THE NOSE THROAT & LUNGS.

H. HOLBROOK CURTIS, M.D., EDITOR.

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EDITORIAL.

In the March number of this Journal appeared an editorial on the subject of heart stimulation which has elicited so much criticism and has been the cause of so much correspondence that it might be well to more clearly define the exact position which we intended to assume in regard to alkaloidal medication. In the question of the manufacture of alkaloids there is but one thing to take into consideration, and that is, their chemical purity. The general reputation of any drug house from a trade standpoint alone should not justify us in the use of an amorphous aconitine provided that there exists a crystalline variety to be obtained elsewhere. It is but a sorry reflection upon the sagacity of our medical men, as well as upon their knowledge of physiological chemistry, that the glucosides should be prescribed so indiscriminately when it is possible to obtain them in a state of approximate purity While we do not lean toward the tenets of any sect, we cannot but acknowledge that the practice of medicine has been appreciably altered by a slow evolution through the influence of homœopathy, hydropathy, etc. To assert that homœopathy had exerted no influence upon the allopathic practice of to-day would be as ridiculous as is the claim of homœopathy for scientific recognition. The endeavor of modern therapeutists is, to obtain drugs of greatest purity in a strictly chemical sense. To this end a sect of so-called dosimetrists has arisen in Europe under the leadership of the venerable Burggræve of Ghent, who has brought to his standard many thousands of European practitioners whose pretensions border upon fanaticism. However absurd these pretensions may at first appear, there is an element of underlying truth in the general scheme which cannot be overlooked or disregarded. Their claim that the physiological effect of a drug, and especially of the alkaloids, bears but slightly upon the effect of the same drug when exhibited in pathological conditions, and more particularly in the febrile state, is certainly a tenable one.

Another feature of their practice upon which they lay especial stress is the so-called "trinity," viz., the alkaloids, aconitine, digitaline, and the arseniate of strychnine, which when given conjointly in doses

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respectively of $\frac{1}{180}$ gr., $\frac{1}{60}$ gr., and $\frac{1}{180}$ gr., combine the properties of a heart stimulant, antipyretic and nervine, acting as a general constitutional tonic. In acute cases, of which pneumonia may be taken as a type, the most extravagant claims are made for the efficacy of the treatment; and, in so far as the statistics of the General Hospital of Ghent are to be relied upon, there is more than a moderate excuse for their enthusiasm. Having made most careful experiments extending over a period of three years, it is the belief of the writer that the so-called heart failure of pneumonia is practically eliminated by this treatment, and the intense exhaustion following general febrile processes is essentially mitigated. This therapeutic fact has been so thoroughly endorsed by many of our colleagues that we feel no hesitation in corroborating the opinions previously expressed in these pages. We fail to see, however, why a clever scientific therapeutic discovery of this kind should have been a sufficient cause, as it evidently has been, for the foundation of a new sect of medicine. Nor have we any sympathy for a body of physicians who constitute themselves apostles of a gigantic proprietary monopoly.

Original Articles.

Intubation in a Case of Diphtheritic Laryngitis in an Adult.

By J. O'Dwyer, M.D., New York.

Mrs P., aged thirty years, mother of three children and in the fourth month of pregnancy, was seized with a chill during the night of October 20, 1889, after exposure to cold the previous day. Hoarseness and swelling of the tonsils and lymphatic glands soon followed.

October 22, or about thirty-six hours from the onset of the disease, I was called to see her by Dr. W. A. E. McKee on account of the development of urgent dyspnœa. I found the patient in the following condition: she was cyanosed, and her breathing labored, inspiration only being obstructed; there was absence of voice and a croupy cough. The mucous membrane of the pharynx was deeply injected, the tonsils very much swollen, but without any trace of fibrinous exudation. Great tumefaction involving all the tissues of the neck from the angles of the jaw and chin to the sternum was the most marked objective feature of the case. The temperature was 103°, the pulse rapid and feeble.

Although in a dazed or semi-comatose condition, she was able with assistance to get from the bed to a chair. I immediately placed the medium sized hard rubber adult tube in the larynx. This was attended with considerable difficulty owing to her inability to open the mouth sufficiently wide to insert the fingers. No relief was afforded and I concluded that I had entered the œsophagus; but on inserting my finger and at the same time pulling on the string so as to lift the head of the tube slightly out of the cavity of the larynx the dyspnœa was relieved. This explained the cause of the failure. The stenosis was not, as I supposed, in the chink of the glottis, but was due to enormous swelling of the epiglottis and ary-epiglottic folds which closed in over the head of the tube producing the same amount of obstruction that existed before. This tube was therefore removed and the largest size inserted, with complete relief to the dyspnœa. Slight inspiratory stridor still remained, proving that some of swollen tissues still overlapped the opening, but leaving ample room for free respiration. The diameter of the head of the first tube used was $\frac{13}{16}$ of an inch, while the larger was a little over $\frac{7}{8}$ of an inch.

Independently of the infiltration of the glands and cellular tissue of the neck which is not pathognomonic of diphtheria, as it also occurs in the phlegmonous form

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of inflammation in this region, the diagnosis of laryngeal diphtheria was made in this case from the excessive tumefaction and rigidity of the epiglottis as conveyed by the sense of touch—a condition which I have never found in any other acute disease of the larynx.

The prediction was therefore made, that should the patient live long enough pseudo-membrane would show itself in the pharynx.

She spent the night comfortably in a semi-comatose sleep, passing urine and fæces involuntarily. The next day, Oct. 23d., there was marked improvement in all the symptoms, the swelling on the outside having subsided to about one-half its original dimensions. There was no material change in the throat except that pseudo-membrane was present on the uvula and posterior wall of the pharynx. She was perfectly conscious, but had no recollection whatever of the operation or of having seen me before. Swallowing was very difficult owing to the rigid condition of the epiglottis and large-headed tube, and nourishment was therefore given by rectum and stomach tube.

On the morning of October 24th the swelling of the visible parts both inside and outside had so far subsided that it was deemed safe to remove the tube, which was accordingly done. The breathing continued free from obstruction and everything looked favorable until the afternoon of the same day, when a miscarriage took place rather suddenly, attended with great loss of blood. When Dr. Dillon Brown, who was called in the absence of the attending physician, arrived he found her pulseless and almost dead. She rallied to some extent under the use of cardiac stimulants, but never sufficiently as to give any hope of recovery. Death took place the next day, but there was no return of the dyspnœa.

The most interesting feature connected with the treatment of this case was the remarkable fact that a difference of less than one-tenth of an inch in the diameter of the heads of the two tubes used, made all the difference between complete relief and no improvement of the symptoms. Of course the head of the larger tube was also slightly thicker in the vertical direction which would serve to hold it higher in the larynx, but the difference in this respect was less than in the other.

What could have been done in this case to relieve the dyspnœa had no larger tube been at hand? Tracheotomy was excluded owing to the enormous swelling of the tissues in front of the larynx and trachea, in addition to a large deposit of fat.

The size of the head of the tube could have been easily increased by slipping over it from below, a piece of rubber tubing, which would be still more effectual if allowed to extend a little above the proximal extremity.

In all my experience with intubation in children, I have met with or at least recognized this condition in only two cases. In one it was not serious enough to necessitate the removal of the tube. In the other it was discovered at the post-mortem.

Removal of a Supra-Glottic Cyst with the Galvano-Cautery Snare.

By Moreau R. Brown, M.D.,
Professor of Laryngology and Rhinology at the Chicago Polyclinic.

Mrs. C. aged sixty-five, of a stout and healthy appearance, came to the Dispensary of the Chicago Polyclinic April 14, suffering from cough and a sensation as if a foreign body were in the larynx.

The patient gave the following history: She was healthy and strong up to the birth of her first child in her twenty-third year. Thence afterwards for twenty-four years, except during pregnancy, she was subject to periodical headaches, sick stomach, violent vomiting, etc. These attacks recurred every eight or ten days.

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She was always thin and sickly except when pregnant. She thought the strain of vomiting and choking caused her throat trouble, which, however, she did not notice till about five years ago, when a tickling sensation in her throat became perceptible. She felt it chiefly when eating, but it was not very annoying until about one year ago. About ten weeks ago she began to cough a great deal and during the past five weeks had coughed almost continuously day and night, so that she had been able to sleep but little. Respiration was at times very difficult. The cough was dry.

On examination with the laryngoscope there was seen on the upper surface of the epiglottis a smooth and globular tumor of a pale color. The tumor was situated on the left side and pressed the epiglottis downward over the laryngeal aperture. Diagnosis: supra-glottic cyst.

April 21.—The tumor was removed by the galvano-cautery snare, after it and the surrounding mucous membrane had been anæsthetized with cocaine.

April 22.—Slight œdematous inflammation of the lingual surface of the epiglottis was observed.

April 23.—Less inflammation was present, the symptoms had almost entirely disappeared, and the patient said she had not slept so well for ten years.

Later.—Entirely cured.

126 State St., Chicago, Ill.

A Case of Electro-Cauterization of the Middle Turbinated Bone, followed by Meningitis.*

By Francis J. Quinlan, M.D.

Lecturer on Laryngology and Rhinology at the New York Polyclinic, etc.

In presenting to the Section the history of this patient, I deem it sufficiently important to detail all the symptoms before and after the operation in order that a careful and honest review of the case may be had. As far as I know there is not a case on record in which cauterization of the nasal chambers has been attended with fatal results.

I therefore submit to your consideration the following observation:

Ella B——, 18 years of age, single, dressmaker by occupation, tall, slender and poorly nourished, came for treatment to the Throat Clinic of the Manhattan Eye and Ear Hospital, Dec. 29, 1889.

The examination, which was confined to the nose and throat, revealed the following symptoms: Obstruction of the nares alternating from the right to the left, pain over the frontal sinus, smell and taste impaired, discharges scanty, constant dropping of mucus into the throat, huskiness of voice. Her digestion was poor, and she was very nervous.

Diagnosis: Chronic hypertrophic rhinitis, ecchondroma and exostosis of septum, chronic follicular pharyngitis.

The patient was seen twice a week during the months of January and February and the hypertrophied inferior turbinated bodies were reduced by the galvano-cautery. The ecchondroma and exostosis were removed with the nasal trephine and Bosworth's saw.

Great relief to nasal respiration followed these operations. Subsequently it was found that both middle turbinated bodies were pressing upon the septum, retaining the secretion, interfering with drainage, impairing the sense of smell, and no doubt causing by pressure the pain referred to in the frontal sinus.

It was thought best to remove portions of the redundant tissue. The patient consented and the alligator forceps was used to do the work. No reaction followed the operations. In a short time the constant dropping of mucus complained of ceased, the headache disappeared and a general improvement of all the symptoms followed. Tonics of cod

* Read before the New York Academy of Medicine, Section on Laryngology and Rhinology, May 27, 1890.

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liver oil and the Syrup of Hypophosphites were ordered and a marked change was apparent. The patient gained flesh, seemed in better spirits, and had the appearance of one much benefited by the treatment.

The above line of treatment was continued during the months of January and February at intervals of two weeks, thus allowing sufficient time between each of the operations to note if any untoward symptoms should occur. After a lapse of six weeks, during which time the girl sustained a severe shock by the sudden death of her father (who was sick only three days with pneumonia), she called again at the Hospital Clinic, stating that although much better she was not breathing as freely through the right nostril as she had done; and upon examination it was found that the mucous membrane covering the stump of the right middle turbinated body was still much hypertrophied and pressed upon the septum. Our patient did not look as well as when she last appeared at the hospital; she had lost flesh, was much depressed, had a poor appetite, was restless at night, and on the whole was far from being up to the standard of health. She was told to call in two weeks, and in the meantime to take two milk punches per day, broths of beef or mutton, and a tonic of iron and strychnia. I believed that her impaired condition was mainly due to the great nervous strain that she had recently experienced by her father's death, and thought nothing more of the matter until she appeared again at the clinic.

She was anxious, she said, for treatment, "as she had received so much benefit before that she was bound to continue it."

On April 19th, the tissues being thoroughly cocainized, the right middle turbinated body was slightly cauterized with the galvano-cautery. No pain was felt during the operation, the patient brightened up, and returned to her home. Some powders of phenacetine, ten grains each, were ordered to be taken every two hours should she experience any pain or discomfort. This operation took place Saturday noon.

I was sent for in great haste on the afternoon following, by the mother of the girl, who stated that since her return home she had had frequent attacks of vomiting and had such pains in her head that she was almost frantic. I found my patient in bed very much weakened from the constant paroxysms of nausea and vomiting, unable to retain any food and complaining of intense pain over both eyes. Her temperature was 99°, skin moist, pulse 100 with occasional loss of beat, but still a good pulse for one so prostrated. The respiration was normal with a marked tendency to sigh; there was the additional symptom of photophobia.

Notwithstanding her weak condition she was able to get out of bed and walk into another room, where she remained seated for some time. A hypodermic of eight minims of Magendie's solution was given, which appeared to relieve her and temporarily control the vomiting. Sinapisms were applied to the epigastrium, and champagne with ice was ordered to be given hourly. I told the family that as the distance was somewhat great from their abode to mine, if she grew worse they had better summon their family physician who lived near by.

I heard nothing until Tuesday afternoon (it was Sunday evening when I saw her), when I was informed of my patient's death. This was most unexpected. On Monday morning the family sent for their doctor who pronounced the case to be meningitis. He had endeavored to control the excruciating pains by the administration of morphine.

She succumbed, however, on Tuesday morning, about seventy hours after the operation.

From Sir Morrell Mackenzie I quote the following:

"But while deprecating unnecessary

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aggression in this tender region I do not deny that there are many cases which can only be cured by active treatment; should hypertrophy resist the ordinary measures recommended, the redundant tissues must be destroyed or removed."

Again, in the latest edition of Bosworth's work the following sentence appears: "The galvano-cautery has come into very extensive use and is warmly advocated by Moldenhauer, Mackenzie, Sajous, Lennox Brown, Seiler, Schech, Robinson, and others. All these writers give it preference over all methods." Further on in the last named author's excellent treatise on this subject he states: "That introducing the electro-cautery in the nose involves a certain amount of risk. Most writers recognise and indeed make special allusion to the violent reaction that may follow its use, giving rise to an acute and distressing neuralgia, an acute dermatitis, and even an attack of facial erysipelas." However, he records no fatal cases.

Sajous, in his recent work, states that he has never met any untoward symptoms following galvano-cauterization. During the last two weeks I have spoken to many of our eminent metropolitan laryngologists and rhinologists, and they are as a unit in agreeing that grave symptoms have never followed the use of the electro-cautery in the nose, beyond a slight reaction for a day or so.

Carl Seiler in a recent communication on this subject states that he has never had a fatal result from the use of the galvano-cautery. In reviewing this case, with its unlooked for termination, I cannot convince myself that the untimely death of this girl was due directly (I emphasize the word) to the cauterization, but to the condition of the patient at the time of this very slight every day operation.

Why did not such a reaction follow the use of the saw (such a case was recently reported by Dr. Baruch with fatal results), or of the drill, the forceps, or even at former cauterizations?

During the three months that she submitted to operations, these agents were employed very heroically at times and still the condition during this period was one of perceptible improvement to the patient and of satisfaction to the attendant. I think Dr. Chappel's paper recently read before this Section is full of interest, wherein direct traumatism in the nasal chambers was stated to have been attended by severe symptoms, many of which lasted for months after the operations.

In dealing with troubles of the nose or throat, requiring the intervention of surgery, I consider it wise and, I would add, essential, to obtain, before operating, a thorough and accurate history of the patient. It is far better that the heroic treatment be denied than that the physician should risk the serious reaction likely to follow operations conducted in doubt or ignorance of the physical peculiarities. A person of slender physique may tolerate operations of this character without any serious results, and again in a person of robust physique, the operation may be followed by severe reaction and grave complications. I recommend, then, a thorough investigation, so far as practicable, and desire to record my belief that to the condition of the nervous system at the time of the operation is, in a greater or less degree, due the gravity or danger of the symptoms and consequences that may ensue.

A Case of Epithelioma of the Tongue and Tonsil.*

By C. E. Bruce, M.D., New York.

J. F. S., aged fifty, a time keeper by occupation, came to the clinic of the Manhattan Eye and Ear Hospital, Dec. 9, 1889, complaining of a lump in his throat, which caused him some pain and interfered to a considerable extent with articulation. He stated that eight months pre-

* Read at the Section of Laryngology of the New York Academy of Medicine, May 27, 1890.

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viously he had swallowed a fish bone, which seemed to lodge in his right tonsil and caused him some discomfort for several days, after which he obtained relief. Four weeks later he began to experience a peculiar sensation of scratching and pricking, with slight pains at times in the same place, especially on swallowing. He could also feel a slight swelling. This gradually increased in size until the above date, when he was unable to swallow solids. His general condition was good, though he had lost some flesh. His weight had been over two hundred pounds.

Examination disclosed a growth, the size of a large walnut, situated on the right side of the base of the tongue, filling the glosso-epiglottic fossa and pushing the epiglottis downward and backward. It also filled the oro-pharynx on that side, pushing the velum upward. It had a broad base around which the finger could readily be passed, and seemed to spring entirely from the tongue. The tonsil was not involved. The growth was rather soft on its surface and hard at the base. There was no ulceration nor glandular enlargement discernible. A provisional diagnosis of epithelioma was made, pending histological examination.

Operation was determined on, and the growth was removed, December 18th, by the galvano-cautery loop, a broad stump being left. There was no hemorrhage and but little shock. As a result of the operation the patient recovered his voice, gained in strength and appetite, and was able to swallow without difficulty solid food. This improved condition persisted for about two months, when, owing to a recurrence of the growth, a second operation was deemed advisable. Another large growth was accordingly removed by the galvano-cautery knife and cold wire snare, and the base was cauterized by the electrode. This cauterization was kept up at short intervals for a month after the performance of this second operation. The immediate effect of this procedure was beneficial, but within a month recrudescence took place, and this time the neoplasm extended as far as the right tonsil. The glands began also to enlarge at the same time and a cachexia developed with some mental depression. A third operation by means of the cutting forceps was resorted to, simply as a palliative measure and from that time on the decline was a steady one.

The patient went to the country and did not return till May 12th. While away in the country he had several alarming attacks of syncope, and on May 18th, when I was sent for to see him I found him suffering from a very severe attack. He was considerably emaciated, complained of great abdominal pain, was restless and at times delirous. I made an examination of the abdomen and found considerable distension and an enormously enlarged liver. I gave him morphine by the mouth and this relieved him, but he died the next morning.

I secured an autopsy with the following result. The whole base of the tongue, tonsil and pharyngeal wall on the right side was found involved in the growth; the larynx and thoracic organs being, however, intact. The liver was enormously enlarged and filled with indurated nodules, some of which had begun to break down. The kidneys and spleen were similarly affected and the vermiform appendix was the seat of a cancerous degeneration.

In the light of this gross examination the provisional diagnosis of epithelioma would seem to be the correct one, or one of primary carcinoma of the liver and secondary carcinoma of the tongue and tonsil. I will report the result of the histological examination at a future meeting.

Translumination of the Larynx and of the Antrum of Highmore, with Demonstrations.

By W. Freudenthal, M.D., New York.

This subject has engaged the attention of laryngologists for about a year, and it is

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to be deeply deplored that the reviver and real founder of it—Professor Voltolini, of Breslau—has died, alas! too early for us.

Now, to get a view of the interior of the larynx we apply this lamp to the external surface of the neck, either at the pomum Adami, or near the cricoid cartilage, and introduce the heated laryngoscopic mirror into the dark pharynx. But this view is quite different from that ordinarily seen.

When we place the lamp at the level of the incisura thyreoidea, then the vocal bands and all parts above them appear of a beautiful red color (of course the epiglottis is dark). But when we place the lamp near the cricoid cartilage, then we get a better survey of the whole subglottic region down to the bifurcation of the trachea, and this view is often more satisfactory than that obtained by the common method. But it must be observed that we have to become accustomed to this peculiar view of the larynx, for it may be said we see mostly in the negative. What in ordinary illumination impressed us as a thickening or an enlargement of a solid mass, in translumination strikes us as a dark object. The rays of light cannot penetrate, and we infer that a solid mass, or a mass subject to the same optical laws, must intervene. We will therefore be able to define more precisely the contour of a tumor, because we see how the mass differentiates itself sharply by its dark outlines from the other parts in view.

Furthermore, we will be enabled to differentiate, in a certain case, between a solid tumor and a cyst, and this point seems to me to be of sufficient importance to give the method a fair trial. A few weeks ago I operated on a man who, a few minutes afterward, happened to be seen by Dr. Hoch, of Philadelphia. The patient had a tumor, the greatest part of which was below the glottis. It was attached to the right vocal band at the front angle, and extended over a little to the left vocal band. By means of translumination I could easily determine that it was a solid tumor, not a cyst, and could gauge the exact size of it. It is true that you could have excluded a cyst in this case even without translumination, but there are cases where this is not so easily done, and for those I think translumination also of value.

In this man, by the way, we could see, the day after the operation, that the œdematous vocal band was much more translucent than before the œdema had set in, and this brings us to the other class of cases where we have a greater penetration of light than normally. This, however, can only be seen where loss of substance has taken place, as in ulcerative processes or in other pathological conditions which admit a greater penetration of light. When Gottstein says, "the reddened vocal band seems just as translucent as the normal," he is correct; but you cannot draw from that a conclusion as to the usefulness of this method generally. Certainly we cannot recognize these changes, but there are others which we can see so much the easier. So, for example, an œdematous vocal band is differently translucent than an infiltrated one. The first is of a strong, light red, *i.e.*, much redder than the normal, the last is much darker. That is a differentiation which is interesting enough to us.

We come now to the translumination of the antrum of Highmore. For the purpose of transluminating this and the nose, the patient takes the small lamp in his mouth; then we see through the nasal speculum that the nasal cavity is light; in fact, the whole face and the eyes seem light sometimes.

Now, when we take into consideration the way these rays of light have to pass, we will easily understand that the first condition of getting a view of the interior of the nose is the permeability of the nasal floor. Thus lately I had a case where, on the floor of the nose, a not very large broad-based polypus was found, which certainly did not occlude the maxillary foramen. Yet on this side translumination gave a

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negative result, while on the other a positive, *i.e.*, light. After removal of the polypus we succeeded in getting light on both sides.

Now if the nasal floor is permeable for the rays of light—which is the rule—then they spread to all sides, and we see the interior of the nose illuminated. If, however, it should remain dark, then we conclude that in the antrum there must be a body impermeable to the rays of light, more generally pus or a solid tumor. Should, however, a cyst filled with serous fluid be in the antrum, which has enlarged the cavity and thinned its walls, then we would be able to see only so much the better.

The presence of hypertrophied turbinated bodies does not seem to interfere, as one might imagine, with translumination, for I have often been able to see more distinctly even when the hypertrophies were well marked. They seem to act like double convex lenses in collecting the light and making it more intense.

It might, perhaps, seem strange to some of you that the translumination of the nose depends so much on that of the antrum, as this lies so far externally to the nasal cavity. But this is certainly so. At present I am treating a genteman for empyema of the antrum. Even after thoroughly removing all visible mucus from the nose, the affected side remains dark and becomes light only after I have syringed the antrum. So I can only assume that in pathological conditions of the antrum, perhaps the thickening of the mucous membranes, or of the bones, or infiltration of pus on the floor of the nose, may also explain why the permeability of the light is completely excluded.

The non-appearance of light in the affected side is such an important symptom that by it we can make the diagnosis of empyema of the antrum. Since August, 1889, I have seen three cases of empyema of the antrum. In all three the non-appearance of light in the affected side could easily be noticed. I operated on them, and found that great masses of fetid pus in all three were discharged.

In those cases where we successfully apply Hartmann's air-douche or B. Fränkel's hanging-down of the head, where we have a permanent dropping of pus, or the different pains, tenderness on pressure over the canine fossa, etc.,—in those cases we can make the diagnosis without translumination; but there is besides these a large number of them where, even for the most experienced diagnostician, great doubt exists. For those cases, I am sure, the translumination will remain of permanent value.

But important as it may be in a given case to make the diagnosis of an empyema, as valuable is it at times when we can say with certainty, "In this patient there is no pus in the antrum!" Once I came very near having a tooth drawn in a patient, when I was convinced by translumination that I was in error. The patient had no pus in the antrum.

Now permit me to add a few words on the pharynx. Voltolini introduced the small lamp behind the uvula, and could see not only the soft palate transluminated, but looking through a nasal speculum saw the whole nasal cavity. This, however, can only be done in rare cases, as the lamp becomes heated very quickly and burns. The application of cocaine, suggested by Voltolini, I would not recommend, as, the sensibility being reduced, the parts are apt to be cauterized unintentionally. So much for the pharynx.

The lamp for the larynx I have modified myself. I was able to see with it in some cases more distinctly, and can handle it easier.

And now, gentlemen, if you want to try this method, allow me to give you some points:

1. For the exploration of the antrum an absolutely dark room is necessary, for that of the larynx not.

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2. Never work without a rheostat, if you don't want to break too many lamps; and,

3. Never forget to ask your patient to take his tooth-plate out of his mouth before examining his antrum. For you might be tempted to diagnose empyema of the antrum on both sides, if you do not use that precaution!

The Case of Signor Campanini.

By H. Holbrook Curtis, M.D.,

It may be of interest to the profession to understand the causes which led to the loss of vocal powers of the great tenor.

Early in January of this year, at the request of Professor Doremus, Signor Campanini presented himself at my office. He complained of a progressive lessening of vocal power, and the absence of that peculiar property known as *timbre*. This condition he first observed following an attack of acute bronchitis and laryngitis five years ago, at which time he had been seriously ill for several months and had experienced profuse hæmoptyses.

Laryngoscopic examination revealed a subglottic growth, apparently surmounted by a small teat or prolongation which was strangulated by the cords in phonation. The general condition of the cords was good, with the exception of a hyperæmic condition at the anterior commissure directly above the situation of the growth, where the vessels were extremely congested and prominent The growth itself was of the size of a small bean and slightly grayer in color than the surrounding membrane.

After consulting with Dr. Joseph O'Dwyer it was decided to remove the growth with the forceps, which on account of the depth of the larynx had to be especially constructed by Tiemann. Situated as the growth was in the depression beneath the anterior commissure it required two months of daily habituation to the instrument before the tongue and epiglottis could be successfully controlled, the patient being peculiarly intolerant of cocaine. This time was taken advantage of in eradicating a catarrhal condition and removing an enchondrosis of the septum. Upon three occasions, when the throat was especially tolerant, I was enabled to grasp the neoplasm and thus remove the greater portion of it. The tumor proved to be a papilloma. Chromic acid was then applied every third or fourth day to the base of the growth by utilizing a flexible lead catheter, the acid being concealed within the eye of the instrument.

After three weeks rest from treatment Signor Campanini was enabled to make his *debut* in public on the twelfth of June before an audience in Chickering Hall, when he demonstrated to his hearers the restoration in great part of his phenomenal vocal powers.

I am indebted to Drs. Joseph O'Dwyer and Robert C. Myles for valuable assistance and hints in the construction of instruments.

Transplantation of the Thyroid Gland. —To prevent the development of cachexia strumipriva or myxœdema after total extirpation of the thyroid gland, Horsley proposed transplantation of the thyroid gland of animals. This has recently been done by Prof. Lannelongue in the case of a cretinoid child fourteen years of age, who suffered from myxœdema. About two-thirds of the left lobe of the thyroid was removed from a full-grown sheep and transplanted into the subcutaneous tissue of the breast of the child below the right mammary gland. Owing to the presence of a myxœdematous tumor in the neck it was impossible to perform the transplantation in this region. The capsule of the thyroid was first stripped off and then the gland was imbedded in the subcutaneous tissue at a depth of three centimetres from the surface. Under antiseptic precautions healing took place promptly. The time is yet too short to determine whether the results will be permanent.—*Bulletin Medical*, No. 20, 1890.

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Proceedings of Societies.

Section of Laryngology of the New York Academy of Medicine.

STATED MEETING, MAY 27, 1890.

Dr. G. Scott exhibited a case showing the posterior pillars displaced and adherent to the vault of the pharynx, with congenital absence of both tonsils.

Dr. W. C. Phillips presented a patient with fissure of the middle turbinated bone, giving the appearance of a congenital double middle turbinate.

Dr. C. E. Bruce read the history of a case of epithelioma of the tongue and tonsil. (See page 103.)

A Case of Electro-Cauterization of the Middle Turbinated Bone followed by Meningitis. Dr. Francis J. Quinlan read a paper with this title. (See page 101.)

Dr. Goodwillie did not think the cause of death in the case reported by Dr. Quinlan was attributed to cauterization of the middle turbinated bone, although he might be inclined to consider it an element in its causation. Of course, removal of the turbinated tissues might give rise to a septicæmia, the symptoms of which might last for some time. He made it a habit in all operations upon the nose to thoroughly wash out the cavity, twice a day at least, with bichloride or some other antiseptic solution, so as to remove from the mucous membrane of the nares all diseased elements that would be likely to undergo absorption into the general circulation.

There was, he thought, another question to be taken into consideration in this connection, and that was the peculiar susceptibility of some patients to cocaine. Just before coming to the meeting of the section he had used a weak solution of cocaine on the turbinated bone of a patient in his office, and there was at once developed a considerable amount of weakness in the limbs as a result of the application.

Dr. Douglas was glad to hear these notes of warning sounded in the paper read by Dr. Quinlan. While he most heartily believed that the so-called catarrh and many of the throat and nose troubles were due to an obstructive lesion in the nasal cavity, and could be cured only by relieving the obstruction, still he thought they might go too far in that direction. He believed a great mistake was made in not first carefully considering the general condition of the patient. He would caution them to be careful in their operations on the nose lest they went too far. He agreed with Dr. Goodwillie in not ascribing the death of the patient mentioned in the paper read by Dr. Quinlan as directly due to cauterization, but he believed that the condition in which the patient was at the time of the operation had a good deal to do with it. It was his opinion that if the operation had been deferred until the general health of the patient had been restored, no fatal results would have followed.

Dr. Phillips said he would like to add a little information of a practical nature to the discussion, which he thought might throw some light on the subject of the meningitis from which the patient died. The attending physician was a neighbor of his and a gentleman of considerable diagnostic skill. He saw him a few days after the death of the patient, and was told by him that there was a strong tubercular element present in the case. His view was that the operation on the nose acted as an exciting cause of the development of an acute meningitis. He did not think that cauterization of the middle turbinated bone had been *per se* the direct cause of the meningitis in this case.

If a patient had a predisposition to some disease of the brain, as this woman evidently seemed to have, then any operation on the nose might serve as an exciting cause for its development, as it might act as the cause of troubles in any other organ of the body in a similar manner.

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The Use and Abuse of the Galvano-Cautery in Throat Practice.. Dr. Henry Schweig read a paper with this title in which he stated that in no class of cases in throat practice did the use of the galvano-cautery promise such brilliant results as in the removal of vascular growths. The removal of papillomata, enchondromata, and mucous polypi could be accomplished by the galvano-cautery, and in anterior nasal and turbinated hypertrophies the most brilliant results had been obtained. In the removal of spur-like projections from deflected septa, which was generally done without the pain attending the use of the saw, drill or chromic acid, satisfactory results had been secured by the galvano-cautery. There was little or no hemorrhage and the resulting slough was easily thrown off. Granular pharyngitis was amenable to no other method that yielded such satisfactory results. In the treatment of this affection it was but necessary to puncture each elevation. The enlargement of the papillæ was easily reduced by puncturing with the cautery.

It was mainly in the pharynx that the abuse of the cautery was carried to an extreme degree. There was no other part of the upper air passage that was more sensitive to the action of the cautery than the pillars of the fauces.

The author next referred to the form of battery it was most desirable to employ for this purpose. The only form of battery, he thought, that should be used and that furnished a current of uniform strength, was the storage battery, provided with a German silver wire rheostat. The surgeon required great discrimination and tact, as well as knowledge of the construction of the instrument employed by him.

Dr. Schweig emphasized the advisability, in dealing with vascular growths, of adopting the method of subcutaneous destruction first described by him at a meeting of the Section of Laryngology, January, 1886, as by this means destruction of the largest growths in this region could be secured without any appreciable breach of surface, and without any interference with the integrity of the mucous membrane. He pointed out the fallacy of destroying the mucous surface when this was not the pathological element, and insisted upon the destruction of only those tissues which were at fault.

The Chairman, Dr. Vanderpoel, said that by the mode of puncturing employed by Dr. Schweig more hypertrophied tissue of the turbinated bodies could be destroyed with less destruction of the mucous surface than by any other method, in his opinion. As the result of the galvano-cautery they sometimes observed an inflammatory action; but, as the author had stated, this apparent reaction was due to the unnecessary scorching of the contiguous tissue when the turbinated body was burned. When the puncture method was employed this was to a great extent avoided. Since the introduction of cocaine in operations on the nares they had been a little more careless in the application of the cautery than they had been previous to the discovery of this drug.

Dr. Goodwillie considered the galvano-cautery the best means they had for removing hypertrophied tissues in the nose, pharynx and throat. To remove hypertrophied mucous membrane from the nares without leaving a scar was the consummation to be wished for, but they could not bring this about in all cases. There were two things that they must bear in mind when dealing with hypertrophies of the turbinated bones. When they looked into the nares and found the inferior turbinates very much enlarged they were to consider whether that enlargement was due to a hypertrophy of the fibrous tissue covering of the turbinated bones, or to a dilatation of the vessels and sinuses. The condition existing in the nose had a bearing on the line of treatment that must be adopted in each particular case. If there were a hypertrophy of fibrous tis-

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sue his method would be scarification. If there was a great deal of fibrous tissue, and one scarification did not seem sufficient, he then employed a double-bladed knife of his own invention, and removed a portion of the tissue. If a large amount of tissue had to be removed he then used an electrode with two blades which made a double and parallel incision, destroying the intervening portion. Before that he employed as a protective agent a nasal shield made of asbestos. The cold electrode was introduced into the nasal cavity and then heated, but as it again became cold before reaching the anterior nares it had no destructive action on that part.

In dilatation of the vessels of the sinuses he employed a thin needle which produced sufficient change to bring about all the needed contraction. Before operating in these cases the cavity was thoroughly cleansed for many days previously. In the course of a few days the ribbon of tissue would slough off and come away spontaneously. When the mucous membrane contracted no scars remained. Follicular growths were cauterized at very small points in the centre of each papilla, which he considered sufficient for all practical purposes, care being taken to destroy none of the surrounding tissue.

Dr. Gleitzman said that he was the first to call the attention of the profession to the wire of Dr. Schweig, in an article published four years ago, and since that time he had used it on many patients and found it adapted for the purpose for which it had been devised. The peculiarity of the wire was that it resembled the steel wire. Its resiliency was due to the metal being an alloy of platinum and iridium; the best to be found having the proportion of two per cent. or three per cent. of iridium to platinum. Several of his colleagues who had used the irido-platinum wire had not as good results in the matter of hemorrhage as he had. He managed to avoid this disagreeable contingency by the following manœuvre. When the wire encircled the hypertrophy he turned on the current sufficiently to singe the tissue, and then interrupted it again. In this manner he consumed half a minute or a minute each time, and by doing so slowly contrived to avoid hemorrhage. He had found good use for the irido-platinum wire in hypertrophies at the base of the tongue. He had removed in this manner hypertrophied tonsils in thirteen cases. If they used a wire of the gauge of twenty-seven, for posterior hypertrophies at the base of the tongue, they would experience no trouble in snaring them off.

He would like to say a word in regard to cauterization of the nasal cavity, as some years ago he had had an unpleasant experience in this region. He made up his mind at that time to abandon the cautery or resort to some other method. It occurred to him that if the nasal cavity were thoroughly disinfected after its application he might derive some benefit from its use. Since that time it had been his custom to spray the nose after using the cautery with a two per cent. solution of carbolic acid or Dobell's solution, and in addition advised the patient to wash out the nasal cavity for the next thirty-six hours with the same solution. Since he had done this he had met with but few patients who were not relieved by this method. His manner of using the cautery differed from that of Dr. Schweig. He made a narrow longitudinal streak through the whole depth of the hypertrophy, and if the hypertrophied turbinate was too large to permit the use of the cautery he employed a sharp knife, placed it on the turbinate at right angles and cut through the tissues. When the healing process had been established they would find the incision had healed in a kind of curve; and where the hypertrophy was greatest a canal would remain which would not swell out again, owing to the fact that it consisted of cicatricial tissue.

He wished to call the attention of the Section to a new caustic he had used dur-

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ing the past four weeks to the exclusion of all others, and with marked success. There were a great many laryngologists who had an objection to the use of the galvano-cautery, and there were a great many cases where it could not be employed owing to the idiosyncrasy of the patient, or to the fact that the occasion did not demand its use. They had for this purpose a large number of chemical caustics, the one most in vogue being chromic acid. This acid in many instances induced running from the nose and produced attacks of sneezing with detachment of the eschar. About six weeks ago he had learned of a new caustic, trichloracetic acid, which he considered an excellent remedy for hypertrophies of the nasal cavity. Its application was simple, and catarrhal symptoms and liquefaction of the eschar occurred in only two out of the ninety-eight cases in which he had used it. The eschar remained dry, the patient was not aware that any application had been made; and in five or six days it could be detached with a pair of forceps, leaving a clean dry surface underneath. This new remedy he would heartily recommend to gentlemen who did not wish to use the galvano-cautery.

Dr. Smith made a few remarks concerning the probability of reaction from applications made to the nasal cavity. It seemed to him that before employing them they should take into consideration the condition of the patient. To be more specific in his statement, he would hesitate before operating to any considerable extent in the nasal cavity, and particularly in employing the cautery, in patients suffering from anæmia diabetes, chronic alcoholism, or in persons of an advanced age, with marked degenerative changes and perhaps also with a pronounced gouty diathesis. In regard to anæmic and gouty individuals they could do a great deal in the way of prophylactic treatment previous to operation. In the case of alcoholic patients, unless that habit could first be kept under control, it seemed to him to be a considerable risk to undertake an operation about the nose, and in old patients he had observed unpleasant results follow in a great many instances. In one case he saw facial erysipelas with subsequent death follow the application of chromic acid to the nasal cavity. He had not made a trial of trichloracetic acid, but would like to know in what respect it differed from monochloracetic acid. After the employment of monochloracetic acid the eschar remained adherent to the tissue until cicatrization had been completed, and thus offered a good protection against the occurrence of adhesions after cauterization.

Current Literature.

What Can and Should be Done to Limit the Prevalence of Tuberculosis in Man?—Dr. E. O. Shakespeare, of Philadelphia, in a paper read before the American Association of Physicians, May 13, 1890, expressed warmly the view that the exciting cause was the bacillus tuberculosis of Koch, that the disease was not hereditary; that it was infectious or contagious, and that inasmuch as this disease caused more deaths than any other, and present modes of treatment were very inefficient, it was the duty of the profession to proclaim these views, and take active steps toward its prevention. There should be destruction of the bacilli in excretions and secretions of the affected, and avoidance as much as possible of association of the well with the sick. Rigid inspection of milk and meat was a necessity. There should be special hospitals for the tubercular.—*Medical Record.*

Hydrogen Peroxide in Diphtheria.—Dr. Elder, of Seaton, Ill., writes to the New York Medical Journal concerning a series of cases of diphtheria for which the peroxide of hydrogen was applied as a membrane-solvent. Others have written in our periodicals on this subject, notably

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Dr. Squibb of Brooklyn, Dr. Love of St. Louis, and Dr. Major of Montreal, but Dr. Elder's results appear to have been so decisive that a description of them will pardon a little repetition. He says: "I armed an applicator with a pledget of absorbent cotton, saturated it with the peroxide in the full strength of the ordinary "ten volume solution," and rubbed it over the membrane several times. The effect was magical. The membrane did not dissolve, but softened; it took on the appearance of whipped cream, let go its hold on the mucous surfaces, and was then easily removed by the applicator. It left a raw surface, showing that the membrane had been really diphtheritic in character." This treatment, in the opinion of the writer, had not the effect of preventing the re-formation of the membrane, but it left a clear surface for the application of other antiseptics, and prevented auto-infection. No sign of blood poisoning appeared in this series of cases. The applications were made once an hour during the four or five days before the membrane ceased to form. Dr. Elder is not positive in regard to the strength of the solution used by him, since the bottle from which he obtained it had no label showing whether it was full strength or not, but he believes that it was the regular ten-volume solution. Dr. Love, commonly diluted the solution with three times its volume of water; he particularizes the deodorant property of the drug in cases giving off an offensive discharge. Dr. Major began with a solution even weaker than that of Dr. Love, increasing it to the full strength as the treatment advanced; in his experience the solution removed the membrane by corroding it, so that the extruded fragments present a more or less porous or honey-combed appearance. — *Journal Amer. Med. Association*, May 10, 1890.— *Medical Age*, June 10, 1890.

The Relation of Diseased Conditions in the Upper Air-Passages to the So-Called Nasal Reflexes.—In a paper read before the N. Y. Academy of Medicine, May 1, 1890, Dr. F. H. Bosworth laid down the following propositions:

1st. The special morbid lesion which gives rise to a paroxysm of perennial asthma is a dilatation of the blood-vessels which circulate in the mucous membrane lining the bronchial tubes, the result of a vaso-motor paresis. This vaso-motor paresis differs from inflammation in that, while constituting apparently its first stage, it shows no tendency to go further. Muscular spasm, therefore, according to the old teaching, plays no part whatever in producing an asthmatic attack.

2d. There are two predisposing causes of asthma. First, that condition of the general system which we call neurosis, under the influence of which an individual becomes liable to vaso-motor disturbances in one portion of the body or another. This I think is as good a definition, from a pathological point of view, as we can give of what we call neurosis. I can only say that, as far as clinical observation teaches us, the one pathological lesion which characterizes the direct manifestation of a neurosis is a vaso-motor paresis in one portion of the body or another. In asthmatics this vaso-motor paresis involves the blood-vessels which circulate in the mucous membrane of the bronchial tubes. The second predisposing cause of asthma is a chronic inflammatory process involving some portion of the upper air-tract. In all chronic inflammation the prominent feature is vascular dilation. The whole mucous membrane of the upper air-tract is very closely and intimately related, one part being in quick and close sympathy with another. A hyperæmia of the blood-vessels of the nose shows a marked tendency to be followed by a similar condi-

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tion of the mucous membrane of the bronchial tubes. This, I think, is necessarily a corollary of what we now recognize as the great respiratory function of the nasal passages, by which the temperature and moisture of the inspired air is nicely regulated and adjusted before its entrance into the bronchial tubes.—*Medical Record.*

Conservatism in Nasal Surgery.—Dr. Charles M. Shields read a paper with this title before the Richmond Academy of Medicine, April 15, 1890. He said that the usually prompt results following the recent surgical methods of treating hypertrophic catarrh had, he thought, been followed by a reaction in favor of the too free use of the galvano-cautery, snare, drill and saw, in nose and throat troubles. He advocated the judicious and proper application of these appliances, and did not consider it conservatism to fail to use them where sensitive nasal areas, or true hypertrophies, were present, or where polypi, exostoses, or other growths required removal; but thought that the majority of the unfortunates who presented themselves for treatment now-a-days were too often confronted with the terrors of these instruments, and that an inspection of their throats and nasal cavities presented a battle-ground that retained the scars and blemishes of the action for years. In nasal catarrh, there were but two conditions in which the galvano-cautery could be properly used—first, where there were true hypertrophies to be destroyed; and, secondly, in the atrophic variety, for an entirely different purpose—*i. e.*, stimulating ulcerated and non-secreting surfaces, as the actual cautery is used for ulcerations on the surface of the body, not *to* the tissues, but just near enough to obtain the stimulation of its heat.

In simple chronic catarrh, or any other varieties, except the two mentioned, he thought that only harm could result from its use, and that it was frequently followed by an erethism of the parts, and an irritation of the entire nervous system. Dr. Shields said that we should never lose sight of the fact that the cicatrice resulting from the use of the galvano-cautery is not healthy mucous membrane, or capable of performing its functions, and that even where such a condition was to be preferred to stenosis of the nostrils, it was only choosing the lesser of two evils.

The excessive use of the cautery often produced cicatrices that were followed by an atrophic condition of the parts.

In the recent treatment of *hay fever*, he thought that the largest percentage of cures must be credited to the galvano-cautery; but that the fact would not atone for the abuse of the agent in improperly selected cases.

Unless there were sensitive spots that produced reflex effects, or hypertrophies that produced mouth-breathing, the patient should not be subjected to the risk of the loss of the sense of smell, atrophic catarrh, nervous depression, or the formation of cicatricial spots that might produce the very condition we are trying to remove—a sensitive spot from which reflex symptoms are produced. There were two instances reported in which these scars had to be dissected out before the reflex symptom could be removed.

The abuse of the surgical treatment of the throat, the speaker thought, had been carried to even a greater extreme than that of the nasal cavities. There was no one who advocated more than he the removal of *hypertrophied tonsils* that impaired respiration, deglutition, or hearing; but if moderately enlarged tonsils did none of these, why remove them?

If *adenoid growths* produced mouth-breathing, or impaired the voice or hearing, removal was imperative. Dr. Shields stated, however, that in a careful examination of the throats of a large number of children he was surprised to find a large percentage of instances where some adenoid tissue was present that exhibited

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no symptom in voice or respiration; and that as this tissue is known to undergo absorption with increasing age, it was unnecessary to remove it where it did no harm.

Fashion with specialists at present referred most of the ill-defined troubles of the throat to the so-called pharyngeal tonsil, as the general practitioner made the liver bear the responsibility of his obscure cases. He thought that many patients presented throats filled with scars in this region that would never have known that they had a pharyngeal tonsil if it had not been the fashion to attribute to that rather indefinite structure most of the evils to which the throat is heir.

After considering the condition which made the straightening of deviated nasal septa desirable, and those that, in his opinion, rendered it unnecessary, the speaker closed his remarks with the hope that the undeniably good results of recent nasal surgery should not be disparaged by a lack of proper conservatism that would bring it into disrepute.—*Virginia Medical Monthly*, May, 1890.

The Treatment of Cancer of the Larynx by Electrolysis.—Dr. Schultz reports the case of a man forty years old, who presented a walnut-sized cancerous tumor of the epiglottis, which protruded into the right sinus, and caused severe dysphagia. The growth was extirpated by Dr. Hahn, the epiglottis, a portion of the right half of the thyroid cartilage and the lymphatic glands around the carotids being also removed. Owing to the soft and brittle character of the tumor a combined subhyoid pharyngotomy and laryngofissure was found necessary. Notwithstanding thorough removal it recurred very rapidly, and, four months after the operation, had attained such dimensions that it could be seen to protrude over the base of the tongue when the mouth was opened, and shut off all view into the larynx. As the patient decidedly refused all further operative interference, Dr. Schultz resorted to electrolysis. The positive pole, to which was attached a broad plate electrode, was applied over the abdomen and the negative lanciform electrode introduced into the tumor. The current strength varied between 20 and 30 milliamperes, the sittings lasting 20 to 30 minutes. After withdrawal of the electrode the growth was dusted with iodoform. A marked improvement was observed even after two applications, and after eighteen sittings the result was very favorable. The dyspnœa and dysphagia had completely disappeared, and the tumor which had been as large as an apple was reduced to the size of a bean.

The author recommends in these cases of malignant tumors a resort to electrolysis before undertaking operative procedures. By the employment of cocaine anæsthesia the application of electricity is rendered safe and easy. — *Berliner Klinische Wochenschrift*, March 10, 1890.

Nasal Syphilis.—Dr. P. Michelson regards the longitudinal ulcers of the septum occurring in syphilitic rhinitis as due to the pressure of the gummatous inferior turbinates upon the septum. On the ground of his statistics of 42 cases he finds that ulcerative syphilitic processes in the nose are most frequently developed during the period of one to three years after infection. In the secondary stage he has observed erosions in the vestibule narium, but has never seen papules or broad condylomata in those parts of the nasal cavity which are lined with true mucous membrane. Two cases of necrosis of the ethmoid bone are reported with detachment of the sequestra. In 50 per cent. of his cases the ulcerative syphilides of the nose were complicated by similar processes in the pharynx and naso-pharynx, and the author therefore recommends a careful examination of these regions even when there are no direct signs of disease.

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The clinical diagnosis between syphilitic and tubercular ulcers is in the author's opinion frequently difficult. He states that tuberculous ulcers have usually a roundish or irregular shape, while syphilitic ulcers are more apt to be longitudinal.—*Volkmann's Sammlung Klinischer Vorträge.*

Muscular Contractures in Tuberculosis.—Dr. Remak, of Berlin, reports the case of a man aged 37, with severe tuberculosis of the lungs and larynx, who presented marked rigidity of the muscles of the upper extremity both in active and passive movements. The muscles were not atrophied, but felt as "hard as stone." The rigidity affected the muscles of the shoulders, arm and neck, and was less complete on the right side. Percussion over the occipital region evoked vigorous contractions of the sterno mastoid and deep muscles of the neck, and the tendon reflex of the masseter was somewhat augmented. The patient suffered from attacks of severe dyspnœa, which could not be referred to the phthisis, but were probably of neurotic origin. There was no paralysis or contractures of the lower part of the body. A careful study of this unique case led the author to conclude that the symptoms were not due to disease of the brain or cord, but were rather of the nature of a reflex neurosis.—*Berliner Klinische Wochenschrift*, April 14, 1890.

Trichloracetic Acid in Diseases of the Nose and Throat.—Dr. Ehrmann, of Heideberg, has employed trichloracetic acid for the removal of hypertrophied tissues from the nose and throat. He regards it as an efficient substitute for chromic acid over which it possesses the following advantages: The caustic action is more intense, but more circumscribed, a firm dry eschar being formed which does not liquefy. The application is less painful and less frequently followed by inflammation of the surrounding parts than in the case of chromic acid, and the eschar is more rapidly detached.

The applications are made with a silver probe, a crystal of the acid being taken up and rubbed into the mucous membrane. Ehrmann has also employed the drug with good success as an astringent in chronic diffuse pharyngitis, painting the mucous membrane with the following mixture:

R—Iodi. puri.....0.15 grm.
Potass. iodide.....0.2 grm.
Acid trichloracetic.....0.3 grm.
Glycerini.....30.0 grm.

—*Munchener Medicinische Wochenschrift*, No. 9, 1890.

Nasal Obstruction as a Factor in Caries of the Teeth and Development of the Vaulted Palate.—Dr. Scanes Spicer states that nasal obstruction means mouth breathing, which in turn causes an abnormal exposure of the teeth, resulting in caries. At the same time nasal irritation and physiological disuse lead to faulty evolution of the bony framework (vomer, etc.), with consequent malformation of the upper jaw.

The signs of nasal obstruction, on which most reliance can be placed, are thus given: (1) Open mouth, dropped jaw and vacant expression of countenance in children; (2) dry mouth and parched throat during night and in morning; (3) clammy, sour taste in mouth on waking; (4) snoring and heavy breathing during sleep; (5) chronic sore throat and other uncomfortable sensations in pharynx; (6) thick, tenacious mucus clogging the naso-pharynx and larynx before breakfast; (8) night terrors in children; (9) ear-ache, deafness and otorrhœa, from catarrhal processes, extending to the middle ear.

Finally, the author recapitulates:—Mouth breathing—the necessary consequence of nasal obstruction—appears to influence the production of caries of the teeth: (1) by increasing the stream of micro-organisms and of oxygen in the inspiratory air current; (2) by producing

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congested and inflammatory states of the buccal mucous membrane, with increased secretion of highly acid mucus; (3) by dessicating the secretions of the mouth, and so favoring their adherence, together with organic *débris*, to the pits and irregularities of the teeth; (4) by the alteration of the position of the lips, cheeks and tongue in relation to the teeth, so that the latter cease to be scoured with saliva by the incessant action of the former; (5) by the substitution of a cold air for the warm bath of saliva which floods the mouth when it is shut, and flushes away any matter that may have collected." The highly arched or vaulted palate, the contracted alveolar arch and certain irregularities of the teeth of the upper maxilla are very frequently associated with chronic nasal obstruction in young persons. This association admits of a rational explanation on the hypothesis that prolonged disuse of the nasal channels for their natural functions, during the growth of the organs leads to stunted evolution of the nasal framework. The septum and sphenoidal sinuses partake in this, and fail to push down the palatine processes of the maxillæ, while the rest of the face, including the freely-used alveoli continue to grow. The median line of the hard palate along the attachment of the vomer tends to retain its infantile position. The weight of the lower jaw—which drops to allow of mouth breathing—acts through the tissues of the cheeks and presses on the superior maxillary alvoli, flattening each lateral curved half, so as to diminish the space available for the eruption of the canines and other teeth, which, therefore, are compelled to assume irregular positions.

The practical outcome of this theory, if proved, will be that caries of the teeth in case of nasal obstruction is a symptom rather than a disease, and that the dental surgeon will have to call in the aid of the rhinologist for its successful treatment. —*London Medical Recorder, April* 20, 1890.

Ozoena. — Dr. Cazzolini recommends insufflation of the following powder into the nasal cavity after previous irrigation with luke-warm water:

R—Salol.....5.0 grm.
Acid. borici.....3.0 grm.
Acid, Salicylici.....0.5 grm.
Thymol.....0.2 grm.
Pulv. talci.....8.0 grm.

—*L' Union Medicale,* No. 14, 1890.

Formulae for Diseases of the Throat.— At the National Clinic of Laryngology of Paris (Dr. Ruault), the following treatment is employed for granular pharyngitis: After thorough cleansing of the affected parts with a pledget of cotton the throat is gargled with a solution of bicarbonate of soda 3 ss. to ʒ vi. of water. The mucous membrane is then anæsthetized with a 20 per cent. solution of cocaine, and then painted with the following:

R—Iodi.
Potass. iodid.....a a 3 ss.
Aqu. destillat..... ..3 iv.–v.

These applications are to be repeated on the fourth to the sixth day.

In ozœna the crusts are softened by irrigating the nose with a 20 per cent. solution of bicarbonate of soda, those which are firmly attached being removed with the forceps. The following is then applied with a brush:

R—Naphthol..... ..... 3 i.
Camphor..... 3 iss.
Ol. Olivae..... ʒ xxx.

To combat the dry character of the mucous membrane, vaseline and olive oil, one to three, is sprayed into the nose.

In tubercular laryngitis the curette is employed, or applications of lactic acid, carbolic acid or iodoform. The patient inhales several times daily with a Siegel's inhaler a solution of carbolic acid, 5 grs. to a pint of water. Internally, creasote is administered in pill form in doses of 1½ minims, eight to twelve pills being given

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daily. In the severe ulcerative forms the affected parts are painted with acid sulphoricin ʒ iii. combined either with naphthol ʒ iii., salol ʒ iv., creasote ʒ iii., or carbolic acid ʒ i. If these solutions are too irritant an emulsion may be made by the addition of equal parts of water.

In nervous cough Ruault recommends:

R—Strychniæ nitrat.. .....gr. i.
Aqu. destillat..... ʒ v.
Acid Salicylic..... .....gr. 2-3.

Six drops are taken twice daily during meals. The Salicylic acid is added to prevent the formation of fungi.—*Wiener Medizin. Wochenschr.*, No. 14, 1890.

Pneumonokoniosis.—Fowler (*Occidental Medical Times*) says that "Elevator Disease" is the name given in Buffalo to the affection produced by the inhalation of grain dust. The average life of elevator men is said to be five years. In California, a similar affection is due to the blasting in mines. On leaving the mines, workmen suffer from dyspnœa, headache vertigo, and, perhaps, nausea. After a while a cough appears, and increases until the patient is compelled to cease work. The base of the lung would be most likely to be affected, the inhaled particles obeying the law of gravitation.—*Times and Register.*

Treatment of Diphtheria.—Dr. Lennox Brown treats diphtheria as follows: *First*, complete removal of every portion of diphtheritic patch, and the rubbing-in, over the exposed raw surface, of a 60 per cent. solution of lactic acid. *Second*, the nostrils were cleansed with a solution of potass. chlorate and borax. *Third*, they were sprayed with a 20 per cent. solution in oil, of menthol, to reduce swelling, and as an antiseptic. *Fourth*, continuous cold, by means of Leiter,s coil, was applied around the neck. *Fifth*, after a dose of calomel and James' powder, biniodide of mercury every three hours, one-eighth of a grain being taken in the twenty-four hours, with cinchona.—*Medical Press and Circular.*

Retro-Pharyngeal Abscess.—Dr. Bokai states that idiopathic retro-pharyngeal abscess originates in every case from an inflammation of the glands at the back of the pharynx. The glandular inflammation and abscess are most frequent between the ages of two months and four years. Constitutional diseases, such as scrofula and rickets, play an important part in their causation. Infectious diseases are less frequent causes, but local diseases of the nose, pharynx and ear are of much etiological significance.—*Wien. Med. Blätter.*

Book Notices.

THE MEDICAL ANNUAL AND PRACTITIONER'S INDEX. E. B. Treat & Co., New York.

The volume appears in an attractive form, and its subject matter is well up to date. A refreshing feature of the work is that it is so much the more concise than the usual books of reference. The part devoted to new methods of treatment affords an excellent summary of the year's progress in therapeutics. The new and popular remedies are thoroughly discussed, and an instructive chapter on sanitation and drainage is added. After a careful perusal of the work we can safely say that American Edition has come to remain.

TRANSACTIONS OF THE ELEVENTH MEETING OF THE AMERICAN LARYNGOLOGICAL ASSOCIATION, NEW YORK. D. Appleton & Co., 1890.

This volume is the best of the transactions which has as yet appeared. No specialist can afford to miss an opportunity of supplying himself with a copy. The addition of colored plates and good illustrations gives the volume an attractive appearance, and the fullness of the reported discussions of the papers adds much to the interest of the reader.

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By Carl Seiler, M. D.

(*From Medical Record, February* 18, 1888.)

"Before I proceed with the operation, however, in a given case, I treat the nasal mucous membrane with a view to reduce the existing hyperæmia, for it is my experience that, if any surgical interference is undertaken at once, the shock following the operation is much more severe, and the wound does not heal as kindly nor as rapidly as when all acute or subacute inflammation has first been removed. For this purpose I use a spray of an alkaline solution, and make local applications with glycerole of iodine by means of a cotton carrier. Formerly I used the ordinary Dobell's solution for the spray, and also as a wash to be sniffed up the nose by the patient, morning and night, but within the last two years I employed instead a solution composed of the following ingredients:

Sodii Bicarb. et Sodii Bibor..... .....ää ʒ viij.
Sodii Benzoate et Sodii Salicylate.....ää gr. xx.
Eucalyptol et Thymol.....ää gr. x.
Menthol ..... gr. v.
Ol. Gaultheria..... gtt. vj.
Glycerine..... ..... ℥ viiiss.
Alcoholis..... ..... ℥ ij.
Aquæ .....q. s. 16 pints.

This formula gives a solution which is sufficiently alkaline to dissolve the thickened secretion adhering to the nasal mucous membrane, and as it is of proper density, it is bland and unirritating, leaving a pleasant feeling in the nose. At the same time it is antiseptic and acts as a deodorizer, being in this respect far superior to Dobell's solution or any other non-irritating deodorizer and antiseptic. As it is, however, inconvenient for many patients to have so large a quantity of solution on hand, one of our Philadelphia druggists made the solid ingredients into a compressed tablet, so that one, when dissolved in two ounces of water, will make a solution identical in its effects with the solution made after the above formula, and my patients prefer them to the solution.

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LEATHER BAGS of all sizes and styles on hand.

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"TARRANT'S"

Manufactured by LEOPOLD HOFF, Hamburg.

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Introduced into the United States by Leopold Hoff, 1866.	Imported by Tarrant & Co., per S. S. Hamburg-Am. Packet Co. since 1869.	Manufactured to-day in the same factory and by the same party as in 1866.

Recognized as the STANDARD NUTRITIVE TONIC

For Convalescents, Nursing Mothers, Sick Children and in all Wasting Diseases.

Superior to any other preparation as a Safe and Pleasant Appetizer and Invigorant and as a Food in TYPHOID FEVER.

CAUTION.—Beware of a substitute Malt Extract put up in a squatty bottle with the names of "Johann Hoff" and "Moritz Eisner" on neck. This new firm, trading under the name "Johann Hoff," for which the Eisner & Mendelson Co. are agents, was in June, 1889, found

GUILTY of publishing a fictitious court decision, of uttering a false affidavit by the Berlin Court, the **GUILTY** Prussian Royal Landgericht, for the purpose of extending the sales of their substitute preparation. *What confidence can be placed in statements made by a firm found guilty of such practices?* In order to protect themselves and patients against substitution, Physicians are requested to specify

TARRANT'S when prescribing **HOFF'S MALT.**

TARRANT & CO.,

SOLE AGENTS AND IMPORTERS, **NEW YORK.**

Established 1834.

ESTABLISHED 1855.

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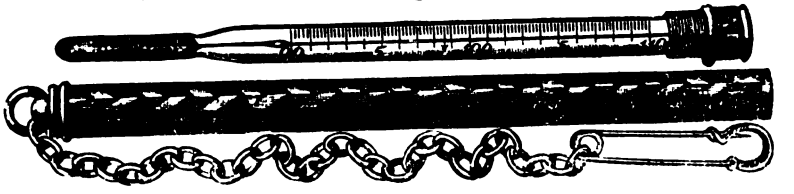
SELF-REGISTERING FEVER THERMOMETERS

With absolutely indestructible and unchangeable Index. Do not increase their readings with age. Ask for a Thermometer with our name, trade mark and 342 on back.

Our No. 342 B has a Jet Black Back, the numbers and degrees enameled white, and is the **best Thermometer** for use in a dark room. Our No. 342A is a White Back Thermometer, with numbers and degrees enameled black.

Solid Silver Case, Chain and Pin, with 4 inch white or black Thermometer..... $2 50 each.

Heavy Gold-Plated Case, Gilt Chain and Pin, with 3½, 4 or 5 inch Thermometer..... $1 50 each.



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"Finally, I may say that it is a mistake to believe that a pepsin does any better work because of its being freely soluble."

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"It has been observed during this investigation, that deliquescent pure pepsins were no better than saccharated in their average strength."—*DR. ECCLES.*

"There is a class of preparations on the market which claim on their labels to be pure pepsin, none of which that I have met with are pepsins at all. * * * *

"These preparations were in the form of scales originally, and changed to this pasty mass on standing in a cool, dry place in my store in uncorked bottles.

"They are soluble in water and by Vittich's and other tests are without doubt peptones, and should never be dispensed except when demanded by the physician."—*PROF. BARTLETT.*

Fairchild's Pepsin is not a Peptone, it is the most active, it is absolutely permanent.

If your patient complains about the powders becoming sticky, investigate—place the blame where it belongs—on the peptone which the druggist has been told is "just as good," "same thing," and "cheaper" than Fairchild's.

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